



## WORLDWIDE AEROMEDICAL EVACUATION SYSTEM

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This instruction implements Air Force Policy Directive (AFPD) 41-3, *Worldwide Aeromedical Evacuation*, by establishing operational and administrative responsibilities and procedures for worldwide aeromedical evacuation (AE). It is consistent with and compliments Joint Pub 4-02.2, *Joint Tactics, Techniques, and Procedures for Patient Movement*. It implements STANAG 3204, SOLOG 83, SEASTAG 3204, and IADB (Inter-American Defense Board) Resolution 46 by incorporating standardized aeromedical evacuation terminology and procedures which under the terms of the above cited documents are binding commitments of the US Government. Do not use this instruction as permission to move patients. Patients must be eligible for aeromedical transportation according to Department of Defense (DoD) Regulation 4515.13-R, *Air Transportation Eligibility*, November 1994, and AFJI 41-315, *Patients Regulating To and Within the Continental United States*. Send comments and suggested improvements on AF Form 847, **Recommendation for Change of Publication**, through channels, to HQ AMC/SGX, 502 Scott Drive, Room 226, Scott AFB IL 62225-5319.

### SUMMARY OF REVISIONS

This is the initial publication of AFI 41-301. It replaces and substantially revises information contained in AFR 164-5, *Worldwide Aeromedical Evacuation*.

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## Chapter 1

### AEROMEDICAL EVACUATION MISSION

**1.1. Mission.** The mission of the worldwide aeromedical evacuation (AE) system is to transport casualties by air, under health care management from:

- Forward airfields in the combat zone to other medical elements in the theater of operations.
- One theater of operation to another.

1.1.1. The Air Force prepares for this mission during peacetime by:

- Training, organizing, and equipping assigned personnel.
- Instructing DoD medical personnel on the use of the AE system.
- Exercising and evaluating contingency AE capabilities.
- Identifying medical and support equipment necessary to meet mission requirements.
- Moving authorized personnel between medical treatment facilities (MTF).

1.1.2. Service personnel, using transportation resources in the combat zone and ship-to-shore, normally manage war casualties forward of the corps area or between MTFs.

1.1.3. The Air Force provides fixed wing aeromedical evacuation:

- Rearward from division or corps areas to the communications zone.
- Within the corps area as required.
- Between theaters.

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## Chapter 2

### RESPONSIBILITIES

**2.1. Air Mobility Command.** The Air Mobility Command (AMC) is responsible for all domestic AE for the United States Armed Forces and for intertheater AE except as indicated in paragraphs 2.3. and 2.4.

**2.2. Air Combat Command.** The Air Combat Command (ACC) serves as the force provider for all ACC and ACC-gained Theater Aeromedical Evacuation System (TAES) assets required to support an intratheater and tactical AE mission primarily for contingency operations. ACC will provide TAES assets to a mature theater to augment existing theater AE or to an immature theater to establish AE capability for the US Armed Forces, except as indicated in paragraphs 2.5. and 2.6.. These systems must:

2.2.1. Provide AE elements to support AE command, control, communications, patient care, and AE system support. Some of these AE elements can be deployed to forward operating locations with forward medical elements and to airstrips at forward operating bases and AE crew members can support AE missions as far forward as aircraft are approved to operate.

2.2.2. Provide Mobile Aeromedical Staging Facilities (MASFs) as required on or in the vicinity of airstrips and air bases for entering patients originating in the airborne objective areas and combat zones who are in need of rapid transport to medical facilities located in the communications zone.

2.2.3. Provide AE in overseas combat areas, including airlift for patients from airborne objective areas, airlift for patients from the point of initial treatment or subsequent hospitalization within the combat zone to points outside the combat zone, and airlift for patients between points within the communications zone.

2.2.4. Provide airlift of patients in an overseas active combat area, or other overseas areas, from points within the area to designated intransit patient facilities.

**2.3. Pacific Air Forces.** The Pacific Air Forces (PACAF) is the theater Air Component Surgeon for United States Commander-in-Chief Pacific (USCINCPAC), and oversees the intratheater AE mission for the Pacific theater to include US Forces Korea (USFK) and US Forces Japan (USFJ).

**2.4. United States Air Forces Europe.** The United States Air Forces Europe (USAFE) is the theater Air Component Surgeon for United States European Command (USEUCOM), and oversees the intratheater AE mission for the European theater.

**2.5. US Army.** The Army component commander is responsible for providing AE by organic Army aircraft within the Army combat zones.

**2.6. US Navy.** The Navy oversees component commander is responsible for providing AE over routes solely of interest to the Navy, where the facilities of the Air Force cannot provide this service.

**2.7. Global Patient Movement Requirements Center (GPMRC)/Aeromedical Evacuation Coordination Center (AECC).** The GPMRC or AECC/TPMRC will:

- Coordinate AE requirements with airlift operations.
- Receive, consolidate, and process requests for patient movement, and where appropriate, transmit these requests to other AE operating elements within the system.
- Monitor intransit patient handling, including the administrative processing of patients at RON stops.
- Monitor appropriate records and submit reports relating to AE activities.
- Coordinate the timely and orderly movement of patients and establishing necessary records to make certain that patients move consistent with their date of travel readiness and operating schedules.
- Consolidate patient movement requests and furnishing necessary assistance to using agencies, including AE liaison functions.
- Prepare reports to reflect patient movement and backlog for the AECC.
- Provide AE Operations Officers (AEOO) for specific geographical areas.
- Advise the destination hospital when a patient is removed from the AE system because of death, medical deterioration, etc.
- Order a quantity of in-flight meals, by type (breakfast, dinner, or supper), and have beverages for flights departing or transiting their stations.
- Coordinate the arrival of the AE aircraft with that of the civilian ambulance agency.

**2.8. Aeromedical Evacuation Operations Officer (AEOO).** The AEOO (whenever possible) will perform duties and responsibilities as outlined in Air Force Handbook (AFH) 41-311, *Aeromedical Evacuation Operations Officer (AEOO) Training Standards*.

**2.9. Medical Crew Director (MCD).** The MCD will insure that the aircraft commander or their designated representative is thoroughly briefed prior to departure on each leg of an AE mission. This briefing may be written or verbal and should include, as a minimum:

- Identification of seriously ill and very seriously ill patients.
- Psychiatric patients who could potentially cause problems during flight.
- Cardiac/respiratory patients who require modulation of cabin pressure changes.
- Any additional information that would assist the aircrew in conducting a safe and comfortable flight.

#### **2.10. Medical Treatment Facilities - Originating**

2.10.1. Originating MTF. The originating MTF supports patients entering the AE system by:

- Transporting them to and from airfields or AE staging facilities, when directed.
- Obtaining and transporting the appropriate diet for the patient.
- Providing appropriate personnel to accompany patients to the aircraft.
- Helping load and unload patients and baggage.

2.10.2. Coordinating With External Agencies. The originating MTF:

- Coordinates with any external or sponsoring agency (or company, in the case of civilian patients) to provide instructions on correct patient care.
- Gets appropriate documentation (equivalent to AE patient orders) from the agency, including proper billing information.

2.10.3. Scheduling Patient Movement. Submit patient movement requests to the Global Patient Movement Requirements Center (GPMRC) or Aeromedical Evacuation Coordination Center (AECC)/Theater Patient Movement Requirements Center (TPMRC) following the guidelines in Chapter 5.

2.10.4. Preparing Travel Orders. Prepares valid, funded travel orders for all US Armed Forces and non-US Armed Forces patients and attendants (revenue reimbursable/pay patients).

2.10.4.1. Prepare the travel order or transportation authorization by:

- Including a complete billing address for non-US Armed Forces patients.
- Attaching "Secretarial Designee" letter (if applicable) authorizing AE and specifying the reimbursement rate.

- Sending a copy of the order to GPMRC, 505 D Street, Room 100, Scott AFB, IL 62225-5049, or send through the Defense Medical Regulating Information System (DMRIS), within 5 workdays after the patient leaves the facility.
- 2.10.4.2. Prevent patient movement delay by authorizing alternate methods of transportation for active-duty Armed Forces patients.
- 2.10.5. Ensuring Entry Requirements. Ensures patients and attendants meet passport, visa, and immunization requirements of the country in which the destination hospital is located.
- 2.10.6. Clothing the Patient. The originating MTF ensures:
- Litter patients who do not wear hospital pajamas wear appropriate conservative seasonal attire.
  - Ambulatory patients wear the appropriate service uniform or civilian clothes.
- EXCEPTIONS:** These clothing requirements do not apply during field maneuvers, field exercises, or other unusual circumstances
- 2.10.7. Transporting Patient to Aircraft:
- 2.10.7.1. The originating MTF delivers litter patients to the aircraft on folding canvas litters, North Atlantic Treaty Organization (NATO) type, secured with two litter straps.
- 2.10.7.2. The litters will be prepared with:
- Mattress.
  - Two blankets.
  - Two sheets.
  - One pillow and pillowcase.
  - Two Litter Straps.
  - Additional items required due to patient needs or weather.

**NOTE:** During contingency operations, each patient must be provided, at a minimum, a litter and two litter straps.

2.10.7.3. Patients with crutches or full leg casts, or whose condition prevents them from using airline seats, will be classified and transported as litter patients. If they are unable to walk up a flight of stairs without the use of crutches, they must be enplaned via litter.

2.10.7.4. Crutches and canes must accompany patients who require such items.

## **2.11. Medical Treatment Facilities - Receiving**

2.11.1. Meeting Aircraft. A representative of the receiving MTF, authorized to receive patients, patient records, baggage, valuables, and accompanying special equipment, meets each aircraft.

2.11.2. Accepting Physicians. Verify your acceptance of urgent or priority patients by calling the GPMRC or AECC/TPMRC.

## **Chapter 3**

### **SELECTION OF PATIENTS FOR AEROMEDICAL EVACUATION**

**3.1. Determining the Appropriateness of Aeromedical Evacuation.** The GPMRC:

- Considers the risks, care, and cost advantages of military AE versus other treatment options .
- Directs questions about AE to the appropriate theater AECC/TPMRC.

**3.2. Physicians Duties.** The attending physician determines requirements for a patient to use the AE system based on the patient's clinical needs. Refer to Air Force Joint Manual (AFJMAN) 41-306, *Physician's Roles and Responsibilities in Aeromedical Evacuation*, for further information and guidance on patient selection and considerations.

3.2.1. DoD and Department of Veterans Affairs physicians who use the AE system:

- Work with nurses and administrators in preparing patients for AE.
- Direct care for the patient until the patient is under the direct care of the receiving physician at the destination medical facility.
- Meet the Joint Commission on Accreditation of Healthcare Organizations standards for patient transfer when using AE.

3.2.2. Physicians who select patients for transportation by air must stabilize them as much as the situation and resources allow. They should attempt to:

- Secure the airway.
- Control hemorrhages.
- Treat shock.
- Stabilize fractures.

**3.3. Patient Administration Officer's Duties.** The patient administration officer determines:

- Whether care is available locally.
- Whether more efficient and cost-effective alternatives are available.

**3.4. Clearing Patients for Aeromedical Evacuation.** The MTF's senior flight surgeon clears all patients that their facility identifies for AE.

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## Chapter 4

### PREPARING PATIENTS FOR AEROMEDICAL EVACUATION

#### 4.1. Briefing Patients Prior to Aeromedical Evacuation during Routine Operations.

4.1.1. Thoroughly brief patients and attendants before departure. Verbal or written briefings should include the following items as applicable:

- An overview of the AE system.
- The potential for remaining overnight (RON) in the AE system and the possible regrouping of patients.
- A specific route (when known), including the estimated time and the number of planned stops (when known).
- Baggage limitation, accessibility, the need for personal funds, personal medical supplies, and appropriate dress.
- US Departments of Agriculture and Customs inspections.
- The availability of in-flight insurance.
- The expectations at the destination medical facility, including procedures for patients and non-medical attendants using aeromedical staging squadrons (ASTS).
- Safety and egress procedures.
- Any other information helpful to the patient.

4.1.2. The aeromedical evacuation squadron (AES) performing the mission ensures that each patient on all scheduled AE aircraft receives an informational pamphlet explaining what the patient can expect during their flight. These pamphlets are customized for each theater of operations (i.e. USAFE, PACAF, CONUS) to assure each patient receives the information necessary to transverse the area they are in.

*NOTE:* This requirement may be impractical during contingency operations.

4.1.3. Each theater of operation will also design a system for obtaining patient comments on the type of service they received.

*NOTE:* This requirement may be impractical during contingency operations.

**4.2. Conducting Anti-Hijacking Procedures and Security.** The originating MTF or ASTS checks all patients, attendants, and baggage to be placed aboard Air Force aircraft or AMC contract aircraft in accordance with AFI 13-207, *Preventing and Resisting Aircraft Piracy (Hijacking)*, paragraph 7.4. At the aircraft, MTF or ASTS representatives will provide the medical crew director (MCD) with a signed statement listing the names of the individuals searched and stating that anti-hijacking measures have been accomplished.. Procedures to follow:

- 4.2.1. Inspect patients and attendants either with either a hand held or walk through metal detector, X-ray machine, or by a physical check.
- 4.2.2. Notify security police if you find suspicious items.
- 4.2.3. Restrict inspected patients and attendants to a holding area.
- 4.2.4. Redo the inspection for personnel who leave a holding area after you have finished.
- 4.2.5. Inspect all hand carried items.
- 4.2.6. Honor requests for visual inspection instead of using X-ray or metal detectors.
- 4.2.7. Competent, non psychiatric patients may keep items such as small pen knives (3 inch blades or less), shaving razors, or small scissors.
- 4.2.8. Deny boarding to individuals refusing anti-hijacking inspection.
- 4.2.9. Identify any patient or attendant showing suspicious behavior to the medical crew.
- 4.2.10. Arrange for guards to accompany prisoner patients to their destination.

*NOTE:* Security police provide guards with appropriate travel orders and funding codes.

- 4.2.11. Conduct all inspections with the highest standard of military courtesy.
- 4.2.12. Exempt classified materials held by official couriers from inspections.

4.2.13. Inform passengers that they can't carry weapons or explosives aboard. If authorized weapons are carried onboard, notify aircrew of seating location of individuals(s) with weapons.

**NOTE:** During exercises or contingencies, patients may be exempt from screening and baggage inspection based on the policy directive of the theater surgeon.

#### 4.3. Patient Records.

4.3.1. Preparing Medical Records and Forms. Place all medical records (clinical records, outpatient treatment records, X-rays, and any other pertinent patient information) in an envelope affixed with a properly completed DD Form 2267, **Aeromedical Evacuation-Medical Records**, or clearly marked with:

- The patient's name.
- Rank or status.
- SSN
- Nationality (if not a US citizen).
- Organization.
- Date of departure.
- Destination.

4.3.2. Prepare histopathological sections accompanying AE patients according to AFM 160-28, *Methods of Preparing Pathologic Specimens for Storage and Shipment*, TM 8-340, NAVMED P-5083, or VA Pamphlet 10-72.

4.3.3. Note that the attending physician prepares DD Form 602, *Patient's Evacuation Tag*.

**NOTE:** See AFJMAN 41-306 and AFJH 41-313, *Aeromedical Evacuation Documentation*, for specific completion instructions.

4.3.4. In contingency operations, use the DD Form 1380, **US Field Medical Card**. However, the information must be transferred to the DD Form 602 when the patient enters the AE system.

#### 4.4. Patient Preparation.

4.4.1. Identifying Medications, Supplies and Equipment. The attending physician writes orders for a 3-calendar-day (intratheater) or 5-calendar-day (intertheater) supply of all medications, IV fluids, tube feedings, and treatment supplies the patient requires.

4.4.2. Completing Documentation. The attending physician assures the necessary forms are completed.

4.4.2.1. Prepare AF Form 3839, **Patient Regulating Data Collection Worksheet**, in accordance with AFJMAN 41-306.

4.4.2.2. With help from the AE clerk or patient administrative personnel, report urgent or priority patients directly to the GPMRC or theater AECC/TPMRC.

4.4.2.3. Prepare DD Form 602, in accordance with AFJMAN 41-306. This form serves as the patients only chart during AE.

4.4.2.4. The destination MTF files DD Form 602 in the patient's medical record.

4.4.2.5. The attending physician ensures the DD Form 602 includes:

- All essential patient information.
- Complete orders for all treatments and medications that the patient requires during travel.

4.4.2.6. The patient administration office ensures information on the SF 502, **Medical Record Narrative Summary (Clinical Resume)**, is transferred to DD Form 602.

4.4.2.7. The attending physician:

- Ensures the accuracy and currency of the information.
- Signs DD Form 602.

4.4.2.8. The attending physician ensures that medical personnel attach a legible copy of the SF 502 to the DD Form 602 for all:

- Inpatients.
- Patients placed into the aeromedical evacuation system.

4.4.2.9. Do Not Resuscitate (DNR) Order. AE personnel are not allowed to accept partial code orders (for example, "CPR only", "no intubation", and "chemical code only").

4.4.2.10. The attending physician must provide the following documentation before the flight:

- Completed AF Form 3838, **DNR Certification for Aeromedical Evacuation**, attached to DD Form 602 according to AFJMAN 41-306.
- DD Form 602 with DNR order spelled out as "Do Not Resuscitate," signed and dated by the attending physician not more than 72 hours before the originating flight.

#### 4.5. Family Members, Minors and Attendants.

4.5.1. Aeromedical Evacuation of Unaccompanied Minors: Any unaccompanied minors (under the age of 18) or any unaccompanied, non-active duty patients who are not capable of directing their own care must have DD Form 2239, **Consent for Medical Care and Transportation in the Aeromedical Evacuation System**.

4.5.1.1. Minors under the age of 14 must have an attendant.

4.5.1.2. If a parent or guardian cannot accompany the minor under 14, the originating medical facility must supply a responsible adult with:

- DD Form 2239.
- Power of attorney (POA) identifying the NMA, non-medical attendant, as the responsible agent for the mission.

4.5.1.3. Minors over age 14 may travel alone, but must have DD Form 2239 or the POA.

4.5.1.4. If the parent or guardian is unavailable to sign DD Form 2239 or the POA for the minor, the originating medical facility may accept a telephone consent with two witnesses who:

- Verify the call.
- Sign DD Form 2239 or the POA.

4.5.1.5. Determining Requirements for Attendants. The attending physician determines the need for medical or non-medical attendants to go with the patient.

4.5.2. Medical Attendants (MA). Medical attendants:

- Serve as the clinical authority for their patient's care.
- Familiarize themselves with the patient and possess the level of skill appropriate to the patient's needs.
- Evaluate or help care for other patients on the AE flight as needed.
- Provide and document patient care during flight and at stops until other MAs relieve them.
- Remain with the patient until a physician accepts them upon arrival at the destination medical facility.

4.5.2.1. The attending physician assigns these kinds of specific medical attendants:

- Advanced cardiac life support (ACLS)--certified physician, or nurses for cardiac-monitored patients.
- Physicians or respiratory therapy technicians for ventilator patients.
- Physicians, obstetrical nurses, or nurse practitioners for obstetric patients on continuous IV medications for premature labor or pre-eclampsia.
- Nurses or technicians (if the AECC/TPMRC requests) for neuropsychiatric class 1A and 1B patients.
- Other special attendants for patients whose needs exceed the capabilities of the AE crew.

4.5.2.2. The GPMRC/TPMRC may also assign other crew augmentees as required to support the mission.

4.5.2.3. Non-medical Attendant. The attending physician may authorize one (or more if necessary) able adult attendant for patients who require:

- Psychological support.
- Help with the activities of daily living.

**4.6. Baggage.** The standard baggage allowance is 66 pounds per patient.

4.6.1. Patients must ship excess baggage as unaccompanied baggage in accordance with applicable service directives.

4.6.2. Under special circumstances, the originating medical facility commander may authorize up to 100 pounds of baggage for a US Armed Forces patient. This must be annotated on the patient's travel orders.

4.6.3. The MTF will:

- Attach DD Form 600, **Patient's Baggage Tag**, to each piece of patient baggage to be stowed.
- Deliver the AF Form 3851, **Patient's Baggage Data**, to the designated AE representative at the time of patient transport.
- Place a copy of the temporary duty (TDY) travel order or travel authorization in each piece of stowed baggage.

4.6.4. The patient may bring a small hand carried bag for personal items for use during travel (including over-night stops).

**NOTE:** During contingencies, a patient may be allowed to carry their unloaded weapon and/or chemical warfare gear as applicable.

4.6.5. Hand-carried bags need to be checked to ensure that:

- For litter patients it can fit on the litter with the patient.
- For ambulatory patients or attendants it fits under the aircraft seat.

4.6.6. If a patient's baggage or valuables are lost and the MTF cannot determine exactly where and how the loss occurred, the MTF or agency:

- Questions the appropriate theater AECC.
- Includes enough information in the inquiry to allow the AECC to trace the items.

**EXCEPTION:** These procedures don't apply to valuables that the MTF has sent by registered mail.



**4.7. Valuables.** Patients should be encouraged not to carry valuables (including cash, checks, military payment orders, bonds, and jewelry) while in the AE system. Following local instruction:

- Conduct an inventory of all patient valuables.
- Coordinate with the next-of-kin to take valuables belonging to unconscious or incompetent patients who originate from military or other Government hospitals or send the valuables by registered mail to the patient's destination facility.
- Convert patient's cash assets over \$50 to a US Treasury Check or DD Form 114, **Military Pay Order**.
- Make checks and military pay orders payable to the patient concerned.

4.7.1. An adequate container of minimum size must be provided for each patient's valuables. The container must be labeled showing:

- Patient's full name
- Grade
- SSN
- Service
- Originating MTF

4.7.2. The flight nurse is not required to accept patient valuables unless the patient is physically present for the flight which the flight nurse is to accompany.

4.7.3. The entire processing of valuables should be witnessed and attested to by a disinterested officer whenever possible.

**4.8. Patient Identification.** Ensure that:

- All patients and attendants, including active duty, dependents, retirees, and others have appropriate identification available (i.e. Armed Services Identification Card).
- All inpatients, regardless of age, wear identification bands while traveling aboard AE aircraft.

**4.9. Weapons.** Patients should not normally travel with weapons. Weapons arriving at the aircraft with patients should be returned to patient's unit or secured by the loadmaster and turned over to appropriate agency at the destination airfield.

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## Chapter 5

### REQUESTING AEROMEDICAL EVACUATION

**5.1. Reporting Patients for AE.** Patients must be eligible for AE under the provisions of DoD 4515.13-R. MTFs desiring to enter a patient into the AE system must submit requests directly to the GPMRC or theater AECC/TPMRC, unless otherwise directed by the appropriate commander.

**5.2. Patient Reporting Information.** With the use of the DMRIS, or alternate manual system, report the following information.:

- Patient's name, rank, social security number (SSN), and branch of service (when applicable).
- Diagnosis (including significant secondary diagnosis).
- History.
- Patient classification.
- Destination medical facility (if medical personnel do not want to send the patient to the closest hospital with the capability).
- Movement priority.
- Name of attendant (as applicable).

**NOTE:** Refer to AFJI 41-315, *Patient Regulated To and Within the Continental United States*, or the DMRIS Manual for further guidance.

5.2.1. When the originating physician determines a patient requires urgent or priority AE (unscheduled movement), the GPMRC or theater AECC/TPMRC is immediately notified. The GPMRC or theater AECC/TPMRC will arrange to evacuate urgent and priority cases to the designated hospital as rapidly as possible.

5.2.2. During contingency operations, patient reporting requirements may be reduced due to operational limitations at the forward areas. When operational situation permits, additional patient information should be forwarded.

**5.3. Determining Movement Precedence.** The attending physician:

- Determines movement precedence.

- Requests movement precedence in accordance with the urgency for delivery to the destination medical facility.
- Directs the accepting physician or representative to confirm acceptance of urgent and priority movement precedence by calling the GPMRC or theater AECC/TPMRC.

5.3.1. Urgent Precedence. Applies only to the need for immediate life, limb, or eyesight-saving procedures. The attending physician:

- Reports these cases directly to the GPMRC or theater AECC/TPMRC.
- Coordinates with accepting physician at destination facility.
- Requests accepting physician contact the GPMRC or theater AECC/TPMRC.

5.3.2. Priority Precedence. Applies to the need for prompt medical care not available locally. The attending physician:

- Reports these cases directly to the GPMRC or theater AECC/TPMRC.
- Coordinates with accepting physician at destination facility.
- Requests accepting physician contact the GPMRC or theater AECC/TPMRC.

5.3.3. Routine Precedence. Applies to all other patients. The attending physician reports these cases through the GPMRC or theater AECC/TPMRC:

**5.4. Determining Patient Classification.** The attending physician classifies patients per attachment 3 and AFJMAN 41-306.

5.4.1. Identify patients who:

- Must travel on a litter.
- May need help during an aircraft emergency.
- May pose a threat to themselves or others.

## Chapter 6

### PREPARING PATIENT AND ATTENDANT MEALS

**6.1. Patient and Attendant Meals.** The originating MTF or supporting medical facility during Remain Over Night (RON) stops:

- Feeds patients between flights.
- Provides cooked therapeutic inflight meals (CTIM) for use during the flight.

6.1.1. The flight kitchen provides all regular diets for both patients and attendants while aboard the aircraft.

6.1.2. All MTFs and flight kitchens supporting AE missions will refer to AFI 41-303, *Cooked Therapeutic Inflight Meals*, for instructions.

6.1.3. Destination medical facilities receiving patients and attendants from an AE mission must provide meals on arrival.

6.1.4. Conditions during contingency operations may limit the availability of obtaining prepared foods locally.

## Chapter 7

### PATIENTS REMAINING OVERNIGHT

**7.1. Responsibilities.** AE missions may require either scheduled or unscheduled “remain-overnight” (RON) stops. MTF commanders at locations where RONs occur is responsible for the care of patients and securing medical records and narcotics during the stop.

7.1.1. MTFs at both scheduled and unscheduled RON stations:

- Provide personnel to help get patients out of and back into the plane.
- Admit and assign patients to the medical facility (civilian or military) or a billeting facility as appropriate.
- Feed patients.
- Prepare and manage records.
- Consult with patients as appropriate.
- Maintain medical equipment.
- Provide medical supplies for the rest of the AE mission as needed.
- Help shelter and transport AE crews.

7.1.2. MTF commanders will also ensure that their personnel complete the following tasks for all RON patients at or near their facility:

- Medically evaluate each patient daily.
  - Record evaluation, treatments, and medications on DD Form 602.
  - Prepare patients both clinically and administratively for further AE travel.
  - Provide safekeeping of patient valuables.
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## Chapter 8

### PERSONNEL, EQUIPMENT, AND FACILITIES AT AIR FORCE BASES

**8.1. Aeromedical Evacuation Flight Surgeons (AEFS).** If flying aboard AE aircraft, flight surgeons serve as the clinical authority for patient care. The MCD retains mission authority and responsibility. AEFSs augment the crew to increase its clinical capabilities. In some instances, when closely coordinated and resources are available, the AE system may provide critical care personnel to augment the standard AE crew and provide required medical equipment to support patient requirements.

**8.2. Providing Medical Equipment for AE.** The originating MTF must use only flight-certified medical equipment for patient care during any AE missions. MTFs question the GPMRC or the appropriate theater AECC/TPMRC on the use of non-certified equipment.

**8.3. Aeromedical Evacuation Minimum On Board Medical Supplies and Equipment Requirements.** The following is a list of the minimal medical equipment and supplies which must be carried during a mission:

- IV Infusion Pump
- Cardiac Monitor and Defibrillator
- Portable Suction Unit
- Patient Liquid Oxygen (PT LOX) *NOTE:* For aircraft without integrated liquid oxygen systems.
- Electrical Cable Assembly Set (ECAS)Pulse Oximeter
- Frequency Converter *NOTE:* For aircraft that do not offer a 115 VAC/60HZ power source.

8.3.1. AE crews will also carry the AE in-flight kit identified in AFPAM 41-316, *Aeromedical Evacuation In-Flight Kit--Packaging Guide*.

8.3.2. For a complete list of equipment authorized by Armstrong Laboratory to use in the USAF AE System, refer to AFH 41-309, *Aeromedical Evacuation Equipment Standards*.

**8.4. Installation Commanders.** When requested, the commander of the installation where the originating or destination hospital is located provides personnel to help get litter patients out of and back into the plane.

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## Chapter 9

### MINIMUM REQUIREMENTS FOR AIRLIFT AIRCRAFT AND FORMS

**9.1. Minimum Requirements for Airlift Aircraft.** Except in emergencies, field exercises, or maneuvers, facilities aboard fixed-winged aircraft must meet the following minimum requirements prior to utilization of the aircraft for AE in peacetime:

- 9.1.1. Sufficient aircraft insulation to reduce noise and increase warmth.
- 9.1.2. Adequate heating facilities.
- 9.1.3. Flexible litter and comfortable seating arrangement to permit placement of patients according to their conditions.
- 9.1.4. Adequate space for in-flight treatment of litter patients. The vertical distance between each loaded litter must not be less than 21 inches.
- 9.1.5. Galley facilities for storage and preparation of in-flight meals for patients.
- 9.1.6. Suitable hand-washing and latrine facilities for patients.
- 9.1.7. Pressurization capability to maintain cabin altitude of between 8,000 and 8,500 feet when at cruising altitude.
- 9.1.8. Competent AE crews must be placed aboard airlift aircraft when moving patients, unless appropriate medical authority authorizes exception in unusual circumstances.

**9.2. Departure Time.** AE flights must depart within three (3) hours of scheduled departure time, subject to weather or other uncontrollable factors. When maintenance or other delays in excess of three (3) hours are anticipated, any suitable aircraft at

the station with a lower priority mission may be considered for diversion to support the AE mission.

*NOTE:* To preclude unnecessary patient holding on the flight line, aircraft departure times are not established on the basis of an Estimated Time In Commission when maintenance is required, but will be scheduled on the basis of Firm Time In Commission.

### 9.3. Forms Prescribed

- AF Form 3838, **Do Not Resuscitate (DNR) Certification for Aeromedical Evacuation**
- AF Form 3839, **Patients Regulating Data Collection Sheet**
- AF Form 3851, **Patient Baggage Data**
- DD Form 2239, **Consent for Medical Care and Transportation in the Aeromedical Evacuation System**
- DD Form 2267, **Aeromedical Evacuation--Medical Records**
- SF 502, **Medical Record Narrative Summary (Clinical Resume)**
- SF 513, **Medical Record - Continuation Sheet**

**9.4. Terms.** For a complete list of terms, refer to Air Force Directory (AFDIR) 41-317, *Compendium of Aeromedical Evacuation Terminology*.

EDGAR R. ANDERSON, JR., Lt General, USAF, MC  
Surgeon General

**GLOSSARY OF REFERENCES, ABBREVIATIONS, AND ACRONYMS*****References***

AFI 11-408, *Aircrew Standardization/Evaluation Program*  
AFI 13-207, *Preventing and Resisting Aircraft Piracy (Hijacking)*  
AFPD 41-3, *Worldwide Aeromedical Evacuation*  
AFI 41-302, *Aeromedical Evacuation Operations and Management*  
AFI 41-303, *Aeromedical Evacuation Dietetic Support*  
AFJMAN 41-306, *Physician's Roles and Responsibilities in Aeromedical Evacuation*  
AFH 41-308, *Aeromedical Evacuation Equipment Standards*  
AFH 41-311, *Aeromedical Evacuation Operations Officer (AEEO) Training Standards*  
AFPAM 41-314, *Worldwide Aeromedical Evacuation Brochure (formally AMC Form 206)*  
AFJI 41-315, *Patient's Regulated to and within the Continental United States*  
AFPAM 41-316, *Aeromedical Evacuation In-Flight Kit --Packaging Guide*  
AFDIR 41-317, *Compendium of Aeromedical Evacuation Terminology*  
MCI 10-202, Volume 1, *Aircrew Training Standards*  
MCR 51-164, Volume 2, *Aeromedical Evacuation Crewmember (AECM) Briefings and Publications*  
MCR 55-1, *Tanker/Airlift Operations*  
AFR 64-3, *Combat Search and Rescue Procedures*  
AFR 76-11, *US Government Rate Tariffs*  
AFI 124-204, *Preparing Hazardous Materials for Military Air Shipment*  
AFM 160-28, *Methods of Preparing Pathologic Specimens for Storage and Shipment*  
DoD 4515.13R, *Air Transportation Eligibility*  
Joint Pub 4-02.2, *Joint Tactics, Techniques, and Procedures for Patient Movement*

***Abbreviations and Acronyms***

**AC**—Aircraft Commander  
**ACC**—Air Combat Command  
**ACLS**—Advanced Cardiac Life Support  
**AE**—Aeromedical Evacuation  
**AET**—Aeromedical Evacuation Technician  
**AECC**—Aeromedical Evacuation Coordination Center  
**AECM**—Aeromedical Evacuation Crew Member  
**AEFS**—Aeromedical Evacuation Flight Surgeons  
**AELT**—Aeromedical Evacuation Liaison Team  
**AEEO**—Aeromedical Evacuation Operations Officer  
**AEOT**—Aeromedical Evacuation Operations Team  
**AEU**—Aeromedical Evacuation Unit  
**AFCC**—Air Force Component Commander  
**AFDD**—Air Force Doctrine Document  
**AFDIR**—Air Force Directory  
**AFH**—Air Force Handbook  
**AFI**—Air Force Instruction  
**AFPD**—Air Force Policy Directive  
**AFRES**—Air Force Reserve  
**ALCC**—Airlift Coordination Center  
**AMC**—Air Mobility Command  
**ANG**—Air National Guard  
**ANGUS**—Air National Guard of the United States  
**AOR**—Area of Responsibility  
**APOD**—Aerial Port of Debarkation  
**APOE**—Aerial Port of Embarkation  
**ARC**—Air Reserve Component  
**ARM**—Aeromedical Readiness Missions  
**ART**—Air Reserve Technician

**ASMRO**—Armed Services Medical Regulating Office  
**ASTS**—Aeromedical Staging Squadron  
**AT**—Air Technician  
**ATC**—Air Transportable Clinic  
**ATD**—Actual Time of Departure  
**ATH**—Air Transportable Hospital  
**ATOC**—Air Terminal Operations Center  
**CHOP**—Change of Operational Control  
**CJCS**—Chairman-Joint Chiefs of Staff  
**CMT**—Charge Medical Technician  
**COMAMC**—Commander Air Mobility Command  
**COMMZ**—Communications Zone  
**CONUS**—Continental United States  
**CRAF**—Civil Reserve Air Fleet  
**CTIM**—Cooked Therapeutic Inflight Meals  
**DCS**—Decompression Sickness  
**DIRMOBFOR**—Director of Mobility Forces  
**DMRIS**—Defense Medical Regulating Information System  
**DNR**—Do Not Resuscitate  
**DoD**—Department of Defense  
**ENT**—Ear, Nose and Throat  
**ETD**—Estimated Time of Departure  
**FCC**—Flight Clinical Coordinator  
**FE**—Flight Examiner  
**FN**—Flight Nurse  
**FOB**—Forward Operating Base  
**FS**—Flight Surgeon  
**GPMRC**—Global Patient Movement Requirements Center  
**HDIP**—Hazardous Duty Incentive Pay  
**ICAO**—International Civil Aviation Organization  
**IMP**—Invited Medical Personnel  
**IAET**—Instructor Aeromedical Evacuation Technician  
**ISOPREP**—Isolated Personnel Report  
**IV**—Intravenous  
**JMRO**—Joint Medical Regulating Office  
**MA**—Medical Attendant  
**MASF**—Mobile Aeromedical Staging Facility  
**MCC**—Mission Clinical Coordinator  
**MCD**—Medical Crew Director  
**MCR**—Multi-Command Regulation  
**MOB**—Main Operating Base  
**MSL**—Manpower Source Listing  
**MTF**—Medical Treatment Facility  
**NAF**—Numbered Air Force  
**NATO**—North Atlantic Treaty Organization  
**NDMS**—National Disaster Medical System  
**NGB**—National Guard Bureau (Army and Air Force) (Pentagon)  
**NMA**—Non-medical Attendant  
**NOD**—Nurse on Duty  
**NOS**—Not Otherwise Specified  
**OCONUS**—Outside Continental United States  
**OPCON**—Operational Control  
**POA**—Power of Attorney  
**RON**—Remain Overnight  
**SAAM**—Special Assignment Airlift Mission  
**SSN**—Social Security Number

**TACC**—Tanker Airlift Control Center  
**TALCE**—Tanker Airlift Control Element  
**TAES**—Theater Aeromedical Evacuation System  
**TPMRC**—Theater Patient Movement Requirements Center  
**TDY**—Temporary Duty  
**USAF**—United States Air Force  
**USAFE**—United States Air Forces Europe  
**USAFR**—United States Air Force Reserve  
**USCINCPAC**—United States Commander-in-Chief Pacific  
**USEUCOM**—United States European Command  
**USFJ**—United States Forces Japan  
**USFK**—United States Forces Korea  
**USTRANSCOM**—United States Transportation Command  
**UTC**—Unit Type Code

## PATIENT CLASSIFICATION

### A2.1. Psychiatric Category:

- 1A Severe psychiatric litter patients. Psychiatric patients requiring the use of restraining apparatus, sedation, and close supervision at all times.
- 1B Psychiatric litter patients of intermediate severity. Patients requiring tranquilizing medication or sedation, not normally requiring the use of restraining apparatus. *NOTE:* Keep restraining apparatus available for use.
- 1C Psychiatric walking patients of moderate severity. Cooperative and reliable under observation.

### A2.2. Litter Category:

- 2A Immobile litter patients, non psychiatric, who cannot move about on their own under any circumstances.
- 2B Mobile litter patients, non psychiatric, who can move about on own their own under emergency circumstances.

### A2.3. Ambulatory Category:

- 3A Ambulatory patients, non psychiatric and non substance abuse, going for treatment or evaluation.
- 3B Recovered patents, returning to home station.
- 3C Ambulatory, drug or alcohol (substance) abuse, going for treatment.

### A2.4. Infant Category:

- 4A Infant, under 3 years of age, occupying an aircraft seat going for treatment.
- 4B Infant, under 3 years of age, occupying an aircraft seat returning from treatment
- 4C Infant requiring an incubator, litter type.
- 4D Infant under 3 years of age, litter type.
- 4E Outpatient under 3 years of age, ambulatory.

### A2.5. Outpatient Category:

- 5A Outpatient ambulatory patient, non psychiatric and non substance abuse going for treatment.
- 5B Outpatient ambulatory, drug or alcohol (substance) abuse, going for treatment.
- 5C Psychiatric outpatient going for treatment or evaluation.
- 5D Outpatient on litter for comfort going for treatment.
- 5E Returning outpatient on litter for comfort.
- 5F Returning outpatient.

### A2.6. Attendant Category:

- 6A Medical Attendant
- 6B Non medical Attendant



**AE PATIENT PREPARATION CHECKLIST (MINIMUM REQUIREMENTS)**

<b>AE ITEM</b>	<b>ACCOMPLISHED:</b>	<b>YES</b>	<b>NO</b>
<b>A. DOCUMENTS TO ENTER PATIENT INTO DMRIS</b>			
AF FORM 3839, PATIENT REGULATING DATA COLLECTION SHEET			
<b>B. DOCUMENTS REQUIRED TO ACCOMPANY PATIENT FOR AE</b>			
1. DD FORM 602, PATIENT'S EVACUATION TAG or AF FORM 3899, AEROMEDICAL EVACUATION PATIENT RECORD			
2. ANTIHIJACKING SEARCH CERTIFICATE			
3. NURSING INPATIENT TRANSFER SUMMARY			
4. NARRATIVE SUMMARY (INPATIENTS ONLY) SF 513 (OUTPATIENTS ONLY)			
5. TRAVEL ORDERS			
6. MEDICAL RECORDS			
7. X-RAYS (AS REQUIRED)			
8. SPECIAL DOCUMENTS			
a. AF FORM 3838 FOR DNR PATIENTS			
b. SF 600, PROGRESS NOTES			
c. DOCTOR'S ORDERS (AS APPLICABLE)			
d. DD FORM 2239 "CONSENT FOR MEDICAL CARE AND TRANSPORTATION IN THE AE SYSTEM" OR A LEGAL POWER OF ATTORNEY (POA)			
<b>C. PATIENT SUPPLIES</b>			
1. MEDICATIONS - ORAL/INTRAVENOUS (3 DAY SUPPLY FOR CONUS AND 5 DAY SUPPLY FOR OVERSEAS)			
2. INTRAVENOUS FLUIDS AND TUBING			
3. DIAPERS/BABY WIPES - CHILD/ADULT			
4. BANDAGES			
5. SUCTION CATHETERS			
6. GLOVES			
7. TUBE FEEDINGS AND SUPPLIES AS WELL AS INFANT FORMULA/BABY FOOD			
8. OTHER SUPPLIES AS REQUESTED BY PHYSICIAN			
<b>D. PATIENT BRIEFING</b>			
1. DESTINATION AS CONFIRMED WITH DMRIS AND THE POTENTIAL FOR EN ROUTE STOPS AND REMAIN OVERNIGHT IN THE AE SYSTEM			
2. NO SMOKING ON AE MISSIONS			
3. PERSONAL FUNDS			
4. OUTPATIENT TRAVEL AT OWN EXPENSE			
5. APPROPRIATE DRESS			
6. BAGGAGE LIMITATION FOR CHECKED AND HAND CARRIED			
7. MANDATORY SEARCH OF BAGGAGE AND PERSON			
8. ACCESSIBILITY TO CHECKED BAGS IS AVAILABLE AT ALL RON STOPS			
9. US DEPARTMENT OF AGRICULTURE AND CUSTOMS INSPECTIONS (IF APPLICABLE)			
10. AVAILABILITY OF IN-FLIGHT INSURANCE			
11. RESPONSIBILITY TO PAY AE TRANSPORTATION CHARGES AND IN-FLIGHT MEDICAL CHARGES (IF APPLICABLE)			
12. PROVIDE PATIENTS AND ATTENDANTS WITH A COPY OF THE WORLDWIDE AE PATIENT INFORMATION BROCHURE AND PATIENT REACTION SURVEY			